INTERIM RULEMAKING NOTICE FORM

Proposed Interim Rule Number **2018-14** Rule Number **He-M 520**

1. Agency Name & Address:

NH Dept. of Health & Human Services
Bureau of Special Medical Services
97 Pleasant Street, Thayer Building
Concord, NH 03301

5. Filing Date: **5/25/2018**

2. RSA Authority: **RSA 132:10-b, IV**
3. Federal Authority:
4. Type of Action:
   - Adoption
   - Amendment
   - Repeal
   - Readoption **X**
   - Readoption w/amendment

6. Short Title: **Children's Special Medical Services**

7. Contact person for copies and questions including requests to accommodate persons with disabilities:

Name:	**David Newton**	Title:	**Legal Counsel – Rules Unit**
Address:	**NH Dept. of Health & Human Services** **Administrative Rules Unit** **129 Pleasant Street** **Concord, NH 03301**	Phone #:	**271-9640**
		Fax#:	**271-5590**
		E-mail:	**david.newton@dhhs.nh.gov**

TYY/TDD Access: Relay NH 1-800-735-2964 or dial 711 (in NH)

The proposed rules may be viewed and downloaded at:
http://www.dhhs.nh.gov/oos/aru/comment.htm

8. Summary explaining the effect of the rule:

He-M 520 sets forth the requirements for services and financial assistance for children with special health care needs. As required by RSA 132:13, the proposed rule contains specific provisions and criteria for administration, application, and eligibility for services and financial assistance.

Most of He-M 520 is scheduled to expire on July 1, 2018. Pursuant to RSA 541-A:19, I(d), the readoption as an interim rule of He-M 520 is necessary to prevent the expiration of this rule before its subsequent readoption through regular rulemaking. The proposed interim rule remains unchanged from the existing rule.

9. Listing of people, enterprises, and government agencies affected by the rule:

This proposed interim rule affects children with special health care needs that qualify under the program for services and financial assistance..

10. Specific section or sections of state statute or federal statute or regulation which the rule is intended to implement.

Rule	Specific State or Federal Statutes the Rule Implements
He-M 520.01 - 520.09	RSA 132:2, X; RSA 132:13

11. Summary of the effect upon the state if the rule were not adopted:

If this proposed interim rule is not adopted, the Department would lack the necessary authority to maintain this program.

12. Proposed date of review by the Joint Legislative Committee on Administrative Rules:

June 15, 2018

13. The fiscal impact statement prepared by the Legislative Budget Assistant

Not applicable.

CHAPTER He-M 500 DEVELOPMENTAL SERVICES

PART He-M 520 CHILDREN'S SPECIAL MEDICAL SERVICES

Readopt He-M 520.01, effective 7-1-10 (Document #9748-A), as amended effective 7-1-12 (Document #10138), to read as follows:

He-M 520.01 Definitions.

(a) "Administrator" means the person who oversees the special medical services (SMS) section of the bureau of developmental services and its contractors.

(b) "Allowable deduction" means the amount subtracted from a household's annual gross income, which represents expenses paid by a household member whose income is counted when determining financial eligibility, and is limited to:

(1) Monthly court-ordered alimony payments;

(2) Monthly court-ordered child support payments;

(3) Monthly household child care expenses when both parents are employed or when one parent is employed and the other parent is functionally unable to care for the child;

(4) Monthly private health and or dental insurance premiums;

(5) Monthly food deduction for a household member with a specialty diet recommended by a licensed clinician, not to exceed $400 per month;

(6) Annual deduction of $1,000 for each additional current recipient in the household, not to exceed $3,000 per household; and

(7) Annual single head of household deduction not to exceed $1,000.

(c) "Annual gross income" means the sum of all income received by the household as listed below:

(1) Including, but not limited to:

a. Wages, salaries, tips, commissions before deductions;

b. Net earnings or Schedule C from self-employment, partnership or business;

c. Net rental income;

d. Dividends;

e. Interest;

f. Annuities;

g. Pensions;

h. Royalties;

i. Government- or state-issued benefits, such as:

1. Public assistance;

2. State financial grants;

3. Social security benefits;

4. Unemployment compensation;

5. Workers compensation; and

6. Veterans Administration benefits;

j. Alimony or child support received;

k. One time insurance payments or compensation for injury or death received;

l. Medical settlements, and

m. Non-medical trusts established for the applicant or any household member; and

(2) Excluding income from sale of property, tax refunds, gifts, scholarships, trainings or stipends.

(d) "Applicant" means the person for whom the application is made and who, if determined to be eligible, becomes the recipient.

(e) "Bureau" means the bureau of developmental services within the department of health and human services.

(f) "Children with special health care needs" means "children with special health care needs" as defined in RSA 132:13, II, namely "children who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally."

(g) "Chronic medical condition" means an ongoing physical, developmental, behavioral, or emotional illness or disability, which:

(1) Is expected to last one year or longer;

(2) Requires extended sequential, medical, surgical or rehabilitative intervention as determined by a diagnostic evaluation performed by a licensed clinician who is board eligible or board certified;

(3) Is one of the following:

a. Genetic condition;

b. Inborn error of metabolism;

c. Pulmonary or respiratory condition;

d. Genitourinary disorder;

e. Musculoskeletal condition;

f. Blindness as defined by 42 USC 416 (i)(1);

g. Deafness as defined by 34 CFR 300.7 (c)(3);

h. Congenital anomaly;

i. Developmental delay from birth to 6 years of age;

j. Limb deficiency, including post amputation;

k. Cranial facial anomaly;

l. Neurologic condition;

m. Digestive system condition;

n. Endocrine abnormality, excluding conditions noted in (4)b. below;

o. Cardiovascular condition;

p. Neuromotor disorder;

q. Spinal cord injury;

r. Hematological disorder;

s. Immunological disorder;

t. Malignant neoplastic disease; or

u. Skin disorder as listed in 20 CFR 404, Subpart P, Appendix 1; and

(4) Is not one of the following:

a. An acute or recurrent condition encompassing the area of routine medical care;

b. A hormonal condition for which long-term replacement therapy is required, such as short stature; and

c. A dental or orthodontic condition except as related to conditions in (3)h. or (3)k. above.

(h) "Date of application" means the date stamped on the SMS application as indication that the application was received by SMS.

(i) "Department" means the New Hampshire department of health and human services.

(j) "Durable medical equipment" means a non-disposable device that:

(1) Can withstand repeated use;

(2) Is appropriate for in-home use for the treatment of an acute or chronic medically diagnosed health condition, illness, or injury; and

(3) Is not useful to a person in the absence of an acute or chronic medically diagnosed health condition, illness, or injury.

(k) "Federal poverty guidelines" means the annual revision of the poverty income guidelines for the United States Department of Health and Human Services as published in the Federal Register (74 FR 4199).

(l) "Financial assistance" means a payment made by SMS in whole or in part for health-related services.

(m) "Health-related service" means a service related to the treatment of a recipient's chronic medical condition, such as, but not limited to:

(1) Therapies;

(2) Medications;

(3) Hospitalizations; and

(4) Durable medical equipment or medical supplies.

(n) "Household" means one or more children under the age of 21 and the adults who are directly related to them by blood, by marriage, or by adoption or who assist in the personal care and rearing of an applicant, all of whom reside in the same home.

(o) "Household income" means the annual gross income of the applicant and the adults included in the household.

(p) "Medicaid" means the Title XIX and Title XXI programs administered by the department that makes medical assistance available to eligible individuals.

(q) "Medical liability" means a household's accrued medically related debt or medical expenses paid within the past 12 months that are not covered by third party liability insurance (TPL), including, but not limited to:

(1) Office visit or prescription co-payments;

(2) Emergency department visits;

(3) Insurance or COBRA payments;

(4) TPL required deductibles; and

(5) Other non-covered medical services.

(r) "Medically necessary" means health care services and items that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

(1) Clinically appropriate in terms of type, frequency of use, extent, site, and duration;

(2) Consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

(3) Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;

(4) No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms;

(5) Not experimental, investigative, cosmetic, or considered alternative by current medical practices;

(6) Not duplicative in nature; and

(7) Proven to be safe and effective, as documented in medical peer review literature.

(s) "Medical supplies" means consumable or disposable items appropriate for in-home use for relief or treatment of a specific medically diagnosed health condition, illness, or injury.

(t) "Net income" means the household's annual gross income minus any allowable deductions, defined in (b) above.

(u) "Provider" means an individual who provides a medical, therapeutic or other direct care service within his or her office, agency, practice, or during a home visit.

(v) "Recipient" means a child with special health care needs who has met the established criteria as described in He-M 520.02.

(w) "Resource(s)" means any funds available to the household, minus any penalties for withdrawal, including, but not limited to:

(1) Checking accounts;

(2) Savings accounts;

(3) Certificates of deposit;

(4) Investments, such as mutual funds, stocks, and bonds; and

(5) Trust funds.

(x) "Special medical services (SMS)" means the administrative section of the bureau of developmental services that operates the Title V program for children and youth with special health care needs.

(y) "Spend down" means the amount of a household's net income which exceeds 185% of that household's federal poverty guideline amount.

(z) "Third party" means any private insurer, health maintenance organization, hospital service organization, medical service or health services corporation, governmental agency, or any individual, organization, entity, or agency which is authorized or under legal obligation to pay for medical services for an recipient.

(aa) "Title V" means the program described in Title V of the Social Security Act. SMS administers the NH children with special health care needs component of Title V as part of the Health Resources and Services Administration, United States Department of Health and Human Services.

(ab) "Title XIX" means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under the Medicaid program.

(ac) "Title XXI" means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the Medicaid program

Readopt He-M 520.02, effective 7-1-10 (Document #9748-A and B), as amended effective 7-1-12 (Document #10138), to read as follows:

He-M 520.02 Application Procedure.

(a) Except for applicants under (i) below, and in order to be determined eligible to receive program services or financial assistance, a signed, dated, and completed application, entitled "Special Medical Services (SMS) – Application for All Services," (November 2012) shall be submitted to SMS for each applicant.

(b) The following documentation shall accompany the submitted application in (a) above:

(1) Supporting documentation of income and resources, as applicable;

(2) Supporting documentation regarding the applicant's health diagnosis;

(3) A signed release of personal health information, which complies with current Health Insurance Portability and Accountability Act (HIPPA) policies as defined in 45 CFR 160.103 and 45 CFR 164.501; and

(4) Documentation of guardianship of an applicant or foster parent status, as applicable.

(c) Within 60 days of the date of application, SMS shall:

(1) Accept and review all applications for program or financial eligibility, in accordance with He-M 520.03 and 520.05; and

(2) Notify the applicant in writing of the applicant's eligibility status and the services for which the applicant is eligible.

(d) SMS's notice of decision shall include:

(1) For eligibility approvals:

a. The beginning and ending dates of SMS eligibility;

b. The approved SMS services;

c. The name and phone number of an SMS contact person;

d. Financial eligibility determination, including the spend down amount, as applicable; and

e. Notice that the recipient shall report to SMS any change in the recipient's medical insurance coverage, including Medicaid or TPL changes, within 30 days of the change; and

(2) For eligibility denials:

a. The reason(s) for denial;

b. Information about the applicant's right to an appeal in accordance with He-M 202 and He-C 200; and

c. Alternate support services information as available.

(e) For an applicant who is determined to be eligible, eligibility shall be effective for 12 months from the applicant's application date, except when any household changes affect the recipient's eligibility status.

(f) SMS shall notify a recipient in writing 30 calendar days prior to the date that eligibility will close, for such reasons as the 12 month eligibility period is expiring, the recipient is turning 21, services provided are no longer available, or there is a household change which affects eligibility status.

(g) A new application shall be submitted in accordance with (a) and (b) above prior to the expiration of current eligibility.

(h) An applicant or recipient shall have the right to reapply at any time after eligibility has been denied.

(i) For those applicants applying for services through an SMS sponsored child development clinic, the following shall apply:

(1) The requirements in (a) – (j) above shall not apply;

(2) A completed "SMS Short Application" (July 2012) shall be submitted to SMS;

(3) A signed release of personal health information, which complies with current Health Insurance Portability and Accountability Act (HIPPA) policies as defined in 45 CFR 160.103 and 45 CFR 164.501, shall be submitted to SMS;

(4) Eligibility shall be effective for 12 months after the application is submitted; and

(5) To maintain eligibility, another application shall be submitted to SMS.

(j) An applicant who submits false or misleading information shall be subject to the provisions of RSA 132:15 and RSA 638:15.

Readopt He-M 520.03-He-M 520.04, effective 7-1-10 (Document #9748-A), to read as follows:

He-M 520.03 Program Eligibility Requirements. To be eligible for services provided under He-M 520.04, an applicant shall:

(a) Be a child with special health care needs;

(b) Be a resident of the State of New Hampshire and not have residency in another state;

(c) Be, or have a parent or guardian who is, a United States citizen or a legal resident alien; and

(d) Be under the age of 21.

He-M 520.04 Services Provided.

(a) Services provided to recipients by SMS or agencies under current service contract obligation with SMS shall include:

(1) SMS care coordination services to:

a. Assist the household in developing and implementing a health care plan for the recipient; and

b. Provide information about available Title XIX and other types of third-party assistance;

(2) SMS psychological and psychiatric consultation services;

(3) SMS nutrition services;

(4) SMS feeding and swallowing services;

(5) SMS specialty services provided through attendance at child development clinics sponsored by SMS; and

(6) SMS specialty services provided through attendance at neuromotor clinics sponsored by SMS.

(b) A recipient shall be limited to the services listed in (a)(3)-(5) above if his or her primary diagnosis is one of the following:

(1) Attention deficit disorder;

(2) Autism spectrum disorder; or

(3) Another emotional or behavioral disorder.

Readopt He-M 520.05, effective 7-1-10 (Document #9748-A), as amended effective 7-1-12 (Document #10138), to read as follows:

He-M 520.05 Financial Eligibility Requirements.

(a) To be eligible for financial assistance, a recipient shall:

(1) Meet the program eligibility requirements in He-M 520.03;

(2) Have a documented chronic medical condition; and

(3) Meet the financial eligibility requirements in (b) through (h) below.

(b) A recipient shall be eligible for financial assistance for health-related services related to the recipient's chronic medical condition if:

(1) The recipient resides in a household with a net income less than or equal to 185% of that household's federal poverty guideline amount and with resources of $10,000 or less; or

(2) The recipient resides in a household with a net income greater than 185% of that household's federal poverty guideline amount and the household's medical liability is enough to reduce the household's spend down amount by 100% prior to receiving financial assistance.

(c) The following shall apply to a household's medical liability and spend down amount:

(1) SMS shall determine a household's medical liability each time eligibility for financial assistance is reviewed;

(2) A household's medical liability shall be used to reduce the spend down amount;

(3) A household's medical liability that is used to reduce the spend down amount in one year shall not be used to reduce the spend down amount in any subsequent year;

(4) Medical liability used to reduce the spend down amount shall not be eligible for payment through financial assistance; and

(5) SMS shall notify recipients in writing of current spend down amounts.

(d) If a household requests payment for services that would otherwise be covered under Medicaid and the household's income would allow it to be eligible for Medicaid, the household shall be encouraged to apply for such Medicaid services within 3 months of requesting financial assistance.

(e) Households that do not apply for Medicaid eligibility for the applicant pursuant to (d) above, shall not be eligible for financial assistance under He-M 520.05 and He-M 520.06.

(f) For purposes of determining financial eligibility, a recipient who meets any of the following criteria shall be considered to be the only individual in the household:

(1) The recipient is an emancipated minor;

(2) The recipient is aged 18 to 21;

(3) The recipient is a foster child; or

(4) The recipient has a court appointed guardian.

(g) A recipient's adult siblings who are 18 or older and share the recipient's residence shall be excluded as household members when the siblings:

(1) Are employed;

(2) Are married; or

(3) Have their own children.

(h) For a child residing with a parent and one or more unrelated adults, the income of the unrelated adult shall be included in the household income if the unrelated adult is a parent of an applicant's sibling.

(i) When a household member reports to SMS and supplies supporting documentation of a change in household net income, SMS shall then reassess financial eligibility.

Readopt He-M 520.06-He-M 520.09, effective 7-1-10 (Document #9748), to read as follows:

He-M 520.06 Payment for Health-Related Services.

(a) SMS shall approve a recipient's request for payment for a health-related service when all the following are true:

(1) The recipient has been determined to be financially eligible in accordance with He-W 520.05;

(2) The health-related service is:

a. Determined to be medically necessary;

b. Related to the recipient's chronic medical condition; and

c. Supported by the recipient's SMS health care plan;

(3) All third party resources, including the recipient's hospital, surgical, or medical insurance plans, have been exhausted, except as allowed by (f) below; and

(4) A bill or invoice for a health-related service is submitted to SMS:

a. Which is itemized and dated; and

b. For which the service date is:

1. Not more than 12 months prior to the submission date;

2. Not prior to the recipient's application date; and

3. Not a date when the recipient was not eligible for financial assistance.

(b) Payments for health-related services shall be paid at the lowest of:

(1) The provider's usual and customary charge to the public, as defined in RSA 126-A:3, III(b);

(2) The lowest amount accepted from any other third party payors; or

(3) The Medicaid rate established by the department in accordance with RSA 161:4, VI(a).

(c) Payment for hospital charges shall:

(1) Include both inpatient and outpatient services; and

(2) Have a maximum of $3,000 per event.

(d) Payment for diagnostic procedures shall have a maximum of $3,000 per procedure.

(e) Notwithstanding (b) above:

(1) Over-the-counter medication and non-prescription medication items shall be paid as submitted if no current Medicaid rate is available; and

(2) The administrator shall approve reimbursement for health-related services over Medicaid rates when:

a. SMS has negotiated a higher payment rate(s) with the provider; or

b. Medicaid reimbursement is less than what was paid out of pocket by the recipient.

(f) The administrator shall approve reimbursement for health-related services not submitted for Medicaid or third-party reimbursement when:

(1) A Medicaid or TPL precedent has been set for denial of equivalent services;

(2) A crisis situation exists that jeopardizes the safety or health of the recipient;

(3) The service is identified in the recipient's SMS health care plan; or

(4) The volume of service is over Medicaid or TPL allowable limits.

(g) With respect to Title XIX, Medicare, or any medical insurance program or policy, SMS shall be the payor of last resort. Nothing contained in these rules shall require SMS to provide payment for medications, supplies, or services.

He-M 520.07 Limitation of Services. Financial assistance provided under these rules shall be provided to the extent that funds for this purpose are appropriated and made available to the bureau by the Legislature and not otherwise reduced or restricted by legislative fiscal committee action.

He-M 520.08 Appeals.

(a) Pursuant to He-M 202, an applicant, recipient, parent, or guardian may request to informally resolve any disagreement with SMS, or, within 30 business days of an SMS decision, she or he may choose to file a formal appeal. Any determination, action, or inaction by SMS may be appealed.

(b) If informal resolution is requested, the administrator shall meet and review with the applicant, recipient, parent, or guardian the financial status or medical condition of the applicant or recipient that pertains to the applicant's or recipient's eligibility.

(c) SMS shall notify the applicant, recipient, parent or guardian of the findings of the review, in writing, within 15 business days of a case review conference.

(d) Formal appeals shall be submitted, in writing, to the bureau administrator in care of the bureau's office of client and legal services. An exception shall be that appeals may be filed verbally if the individual is unable to convey the appeal in writing.

(e) If a hearing is requested, the following actions shall occur:

(1) Services and payments shall be continued as a consequence of a request for a hearing until a decision has been made; and

(2) If SMS's decision is upheld, funding shall cease 60 days from the date of the denial letter or 30 days from the hearing decision, whichever is later.

He-M 520.09 Waivers.

(a) An applicant, parent, or guardian may request a waiver of specific services as outlined in He-M 520 using the form titled "NH Special Medical Services, services waiver (July 2010)".

(b) A completed waiver request form shall be signed by the applicant, parent, guardian, or provider indicating agreement with the request.

(c) The request for a waiver shall be granted by the commissioner or his or her designee within 30 days if:

(1) The alternative proposed by the applicant, recipient, parent, or guardian meets the objective or intent of the rule;

(2) The alternative proposed does not negatively impact the health or safety of the household or recipient;

(3) The alternative proposed does not affect the quality of services to a recipient; and

(4) All other TPL service requests have been exhausted or denied.

(d) A waiver request shall be submitted to:

Department of Health and Human Services
Office of Special Medical Services
State Office Park South
129 Pleasant Street, Thayer Building
Concord, NH 03301

(e) No provision or procedure prescribed by statute shall be waived.

(f) The determination on the request for a waiver shall be made within 30 days of the receipt of the request.

(g) Waivers shall be granted in writing and remain in effect for the duration of the recipient's current eligibility.

(h) Waivers shall end with the closure of the related program or service.

APPENDIX

Rule	**Specific State or Federal Statutes or Regulations which the Rule Implements**
He-M 520.01 - 520.09	RSA 132:2, X; RSA 132:13